California Health Policy and Data Advisory Commission
1600 Ninth Street, Room 432
Sacramento, California 95814
(916) 654-1817
FAX (916) 654-1832
www.chpdac@oshpd.ca.gov

Minutes
California Health Policy and Data Advisory Commission
June 22, 2007

The meeting was called to order by Vito Genna, Chair, at approximately 9:30 a.m., at the Crown Plaza Hanalei, San Diego. A quorum of half of the members plus three was in attendance.

Present:

Vito J. Genna, Chairperson
William Brien, MD
Marjorie Fine, MD
Howard L. Harris, PhD
Adama Iwu
Josh Valdez, DBA
Sol Lizerbram
Corinne Sanchez, Esq.
Sonia Moseley

Absent:

Janet Greenfield, RN
Kenneth M. Tiratira, MPA
Jerry Royer, MD, MBA

CHPDAC Staff: Kathleen Maestas, Acting Executive Director; Terrence Nolan, Office Manager

OSHPD Staff: David M. Carlisle, MD, PhD, Director; Elizabeth Wied, Chief Counsel; Michael Rodrian, Deputy Director, Healthcare Information Division; Joseph Parker, PhD, Health Quality and Analysis Division; Jonathan Teague, Manager, Healthcare Information Resources Center; Kenny Kwong, Manager, Accounting and Reporting Systems; Irene Ogbonna, Analyst.

Also Present: Patricia Small, Director, California Health Information Association Board of Directors; Vickie Ellis, representing California Health Information Association; Eric Zimmerman

Approval of Minutes: A motion was made by Corinne Sanchez and seconded by Josh Valdez to approve the minutes of the April 20, 2007 meeting. The motion was carried.

Chairman's Report: Vito Genna, Chair

At the last meeting, the Commission charged both the Health Data and Public Information Committee (HDPIC) and the AB 524 Technical Advisory Committee (TAC) to hear presentations on adding data elements to the Patient Discharge Data Set from Dr. Pine, Dr. Bindman and staff.

A number of Commissioners attended this meeting as well, and their observations will help inform the discussion that will take place at the conclusion of the current CHPDAC meeting pertaining to the four motions that were passed by the HDPIC and TAC subcommittees. Chairperson Genna stated that the information and motions are still preliminary in that there is much study, formalized discussion, and cost benefit analysis that needs to take place.

HDPIC Chairperson, Harris reported that he felt both Committees had passed motions that reflected their desire to see the Commission urge that the effort to add data elements continue without committing to any specific adoptions at this time.

Commissioner Fine stated that she got the sense that the people who would actually have to do the data collection at the healthcare facility level felt that they were not prepared to handle it, either financially or administratively. And everyone agreed that although we had the right to request additional information, it was not certain that they felt that they could handle that request.

OSHPD Director's Report: David M. Carlisle, MD, PhD, Director, OSHPD

Governor Schwarzenegger recently appointed Maria Giuriato the Executive Director of the Health Professions Foundation.

The Office will be relocating in October, the headquarters in phase one and FDD in phase two.

Healthcare reform continues to move forward and the Office continues to be involved in discussions, presentations and meetings around the State. One particular component relevant to OSHPD is our reform of the Seismic Safety Program using the Hazards United States software program. The Hospital Building Safety Board met earlier this week and recommended to the Office that we implement HAZUS and that we shift our specification for seismic performance from what is called complete economic nonperformance as a criterion to collapse of hospital buildings.

The Commonwealth Fund just released a report called "Aiming Higher," which is available on the web. This report compared all the states in the United States in terms of six health system performance criteria. The criteria were access to care, quality of healthcare, an efficiency measure that is called avoidable hospital use and cost, a measure that is called healthy lives and a measure that is called equity.

California had an aggregate rank of 39 out of 50 states across all measures. This is an important report for the State of California and speaks to what the California Health Policy and Data Advisory Commission is involved with in terms of improving quality of

care within the State. This report also speaks to the immediacy of both the Office's and the CHPDAC's work and how important it is to improve health within the State of California. The value in the report is that there are some major challenges ahead that need to be addressed, particularly in the quality of care area which the focus and purview of not just this Commission, but a major part of the work of the Office.

One caveat, in analyzing these measures, is the conclusion that many of these are driven by access to care. If you don't have access to healthcare, quality suffers as does efficiency and healthy lives. This is why the Governor's proposal to achieve universal health insurance within the State of California is so critical. Without having universal health insurance, we cannot achieve higher performance in many of the health dimensions so important to the State.

Commissioner Valdez asked if there was any definition surrounding the term "avoidable hospital visits" so frequently cited.

Director Carlisle stated that there has actually been a fair amount of scientific work invested in defining avoidable hospital admissions. But the real meaning of the definition is not that the actual immediate episode was unavoidable, it is really signaling a break down of the primary care pathway, the continuum that has collapsed at some point, making an emergency room visit or a hospitalization at that point inevitable. That should not be happening in our healthcare system.

Dr. Parker stated that the Agency for Healthcare Research and Quality also published a report on the state of quality of healthcare throughout the United States. Not all states were represented, only those states for which it had patient discharge data, using quality measures such as process and outcome measures. California actually did average or better than average on all the measures.

Director Carlisle amplified what Dr. Parker said, by adding that in terms of assessing quality of care, the Office's focus has been outcomes of care, the gold standard. This is why the Office invests so heavily in risk adjustment models and why the integrity of the data is so important. OSHPD wants to level the playing field so that we can look at the end of the entire care process. For a patient, when they go into a hospital, the most important thing is that they are able to be discharged and be a healthier and more functional person. That is why OSHPD focuses on outcomes; they are the real bottom line for healthcare.

Legislative Update: Patrick Sullivan, Assistant Director, Legislation and Public Affairs

The legislative calendar is a little more than half complete. All the bills that have been introduced in their house of origin, that are still active, have passed off their respective floors and have to go through the other house. Bills that have not been voted off their floors, are now considered two-year bills or failed.

After the budget is passed and the summer recess, the legislative activity will start up with the final committee hearings in appropriations, and then appropriate floors.

AB 295, by Assembly Member Lieu would require specified state agencies to use additional separate collection categories and tabulations for other major Asian and Pacific Islander groups, including Bangladeshi, Fijian, Hmong, Indonesian, Malaysian, Pakistani, Sri Lankan, Taiwanese, Thai, and Tongan. This indicates the direction that some legislators would like to take incorporating increased demographic information.

AB 611, by Assembly Member Nakanishi, would establish a physicians assistant education loan program within the California Health Professions Education Foundation. The program may be difficult to implement as this would be a voluntary program, and the physicians assistants would not be required to contribute to the fund.

AB 1559, by Assembly Member Berryhill, would require a community college district governing board to adopt and implement a merit based admissions policy for an associate degree nursing program if, for any academic term, there are more applicants seeking enrollment than can reasonably accommodated.

SB 26, by Senator Simitian, would with specified exceptions, require any state agency, board, or commission that directly or by contract collects demographic data to provide forms that offer respondents the option of selecting one or more ethnic or racial designation according to specified federal standards.

SB 139, by Senator Scott, would create a Healthcare Workforce Clearinghouse. The clearinghouse, to be administered by the Office of Statewide Health Planning and Development (OSHPD), would serve as the central source of healthcare workforce data in California. OSHPD would collect, analyze, and distribute information on educational and employment trends for healthcare occupations in the State. This would give policymakers a better understanding of healthcare professions and education in meeting future needs.

SB 615, by Senator Oropeza, would require the board to collect an additional fee of $10 at the time a pharmacy license or pharmacy technician license is renewed to be deposited in the California Pharmacy Technician Scholarship and Loan Repayment Program Fund.

SB 764, by Senator Migden, would require the Office to receive, and the Medical Board of California and the Osteopathic Medical Board of California to provide, information respecting individual board licentiates upon request by the Office.

There were a number of bills that failed. One bill, by Senator Migden, pertained to OSHPD collection of medical errors. The Office gets a number of phone calls from the media requesting data on medical errors. The data collected on medical errors is currently housed at DHS and is not necessarily easy for reporters to access.

Joint AB 524 TAC/HDPIC Meeting Introductory Remarks: Michael Rodrian, Deputy Director, Healthcare Information Division

OSHPD is looking forward to moving ahead with additional measures for quality assessment, but there is a ways to go. There were a number of excellent presentations

at the joint meeting of the AB 524 Technical Advisory Committee and the Health Data and Public Information Committee. Now staff need to take the next step in examining these additional measures on the whole spectrum of implementation; what do they measure, how difficult are they to collect, what is the cost and what is the benefit.
Legislation requires us to do a cost benefit analysis which will take some time. OSHPD wants to move forward on the most beneficial measures because it takes time and effort to do the analysis. The best place to start is what makes the best policy sense in terms of measuring quality of care, and that is what staff has been working on with the previous presentations to the subcommittees. Staff is prepared to show the Commission we are in the process and then take the next step as recommended by the Commission.

Healthcare Outcomes Center Report: Joseph Parker, PhD

The Technical Advisory Committee (TAC) was informed of progress made on the patient discharge data validation being conducted by Dr. Andy Bindman and Associates. Ten hospitals out of 48 have had their data reabstracted so far. The study's focus is primarily on the validity and reliability of the coding of the condition present at admission (CPAA) and do not resituate (DNR). Another area is e-codes for accidents to insure that the place where an accident occurs is being recorded consistently. Often this is unspecified and staff is trying to get more of this missing information filled in by hospitals.

The heart attack risk model progress report will be presented at the upcoming TAC meeting to be held in August. There are some DNR issues that have come up. DNR is an important risk factor in these models and hospitals do not always code it the same way. Some hospitals have systems that encourage coding of DNR, some do not pay any attention to it. So having a DNR code does not always mean that the patient is at the same level of risk of death across facilities and that brings problems into the risk adjustment model. Staff will present analyses of that at the August TAC meeting.

There is continued progress on the maternal outcomes report. OSHPD now has a draft report using the data that the contractor was originally contracted to use. Staff will refresh the data using 2003 and 2005 data. The report should go out in 2008.

Staff is also working on the new model for Congestive Heart Failure (CHF) using a benchmark report approach. The aim of the benchmark approach is to get a report that is more timely, so staff will not be waiting on the 30-mortality measure from Department of Health Services (DHS). The hope is that this method will allow a report to be generated approximately nine months after the end of the PDD data reporting period. This approach will be presented to the TAC for feedback.

At the last Commission meeting held in April, Mary Tran, PhD, presented the patient profile report. That is an overview of the patient discharge data, emergency data, and ambulatory surgery data, and where they intersect. The final set of analyses may be released in the form of a fact book. There will be another presentation at a future meeting of the Commission.

The main topic at the present meeting is the list of new data elements that was recommended to the Commission for its consideration. Staff is calling this list the first

priority data elements. These are the 15 data elements that were taken out of a list of 23. The motions that have been sent for consideration by the Commission also allowed for some leeway knowing that some of these first priority data elements might not do well on the legislative criteria used to evaluate them. And so we have some leeway to pick from a second priority data element list, bringing the total number of data elements contained in the current motions to 23.

There are provisions in the Health and Safety Code that must be considered before staff move on to the regulatory aspect of this process. Once the regulatory process begins, some data elements may fall out through the public hearing process. Utilization of sampling, feasibility of collection, and cost and benefits all must be considered. Some of the data elements may fair poorly by some of these criteria. The list may be less than 15 when the regulatory package is prepared. The law does not say that the list must be 15.

The Office is interested in limiting the number of data elements that have to be studied. Dr. Parker stated that what he would like the Commission to consider with respect to the motions before the Commission is to move forward with the analysis of 18 of the data elements.

Dr. Parker presented a chart listing all the data elements and outlined the following breakdown as to which 18 data elements staff felt merited further study and review.

OSHPD recommends:

- Laboratory Values on Admission
    - Aspartate Transaminase (AST): CMP
    - K (Serum Potassium): BMP
    - Na (Serum Sodium): BMP
    - pH (blood gas)
    - Albumin: CMP
    - Creatinine: BMP
    - Blood urea nitrogen (BUN): BMP
    - Platelets: CBC
    - White blood cells: CBC
    - Hematocrit/Hemoglobin: CBC
    - Glucose: BMP
- Vital Signs on Admission
    - Pulse/heart rate
    - Systolic/Diastolic Blood Pressure
    - Respiration
    - Temperature
    - Oxygen Saturation (by pulse oximetry
- Non-Clinical Data Elements
    - Geocoded Patient Address
    - Operating Physician ID

(BMP: Basic Metabolic Panel; CMP: Comprehensive Metabolic Panel; CBC: Complete Blood Count)

OSHPD recommended that the following not be studied further:

- Laboratory Values on Admission
    - International Normalized Ration (INR)
    - Altered Mental Status
- Non-Clinical Data Elements
    - Time of Procedures
    - Time of Admission
    - Identifier Linking Mother to Newborn

Once staff has received the Commission's recommendation, the regulatory package could be ready in six to nine months. It could be longer given other priorities such as the Governor's Healthcare Reform Proposal.

Commissioner Fine stated that since the burden will be on healthcare facilities, the onus is on those involved in this process to act definitively because the healthcare facilities will have to buy the software necessary, or have it created, to work within their medical record systems to facilitate the information that is being requesting.

Deputy Director Rodrian said that was part of the reason why six to nine months are needed to do feasibility analysis, to see what can be captured, whether it has to be a manual collection, or whether it can come out of automated, noting that the federal government is moving in the same direction.

Commissioner Fine asked with regard to the list, how is the data that is now being collected used beyond the internal use within OSHPD? Would it be possible to have a presentation on how this data is being used?

Deputy Director Rodrian stated that many researchers use the data that OSHPD collects. A presentation focusing on who uses the data and how the OSHPD data is used could certainly be made at an upcoming meeting.

Commissioner Brien called for a discussion on the merit of having glucose on the recommended list. He stated that although glucose brought about the most discussion at the joint meeting, there was no scientific basis in the studies for measuring glucose. Glucose is not on the lists of recommendations made by Dr. Bindman, Dr. Pine or Dr. Haas. Commissioner Brien felt that the Committee's wish to include glucose was related to the issue of diabetes and management issues related to glucose. From a scientific stand point, a single glucose measure, taken at any time during a hospitalization, probably isn't representative of the Committee's assessment that it somehow relates to management and control of diabetes.

A number of Commissioners voiced concerns as to why INR (International Normalized Ratio) was being dropped from consideration for further study and why Operating Physician ID was added to the list for further study. Dr. Pine's work showed that INR's value was strongly supported by scientific data. As an example of the difficulty posed with Operating Physician ID, Commissioner Fine stated that unlike Coronary Artery Bypass Graft (CABG) where that is the only procedure of the hospital stay, with trauma patients or substance patients, there may be a number of different physicians involved.

Dr. Parker responded that glucose was added because there was a strong need expressed from some of the TAC members, not necessarily on the strength of the scientific numbers. The decision to remove INR from the list is related to the fact that it does not appear on the basic metabolic panel. The issue is to avoid unnecessary testing and additional measurements for hospitals that will increase costs. The current list represents what the TAC and HDPIC Committees voted forward and the Commission has the opportunity to make changes to that list at this time.

Chairperson Genna explained that at the joint meeting both Committees heard the presentations by Dr. Pine, Dr. Bindman and staff, after which they had independent discussions conducted in each others' presence concluding in the passage of independent motions. Both Committees made motions to have OSHPD go forward with a list of data elements which would require further study and cost analyses. Chairperson Genna encouraged the Commission to be mindful of OSHPD's charge to collect, integrate and distribute data on health outcomes cost and utilization, and pricing, to be used by purchasers, health plans, providers, and consumers in considering the motions.

Health Data and Public Information Committee member Ellis commented that the initial motion before that committee failed to pass because there was great concern that OSHPD would be moving forward on the additional data elements before the definitions were completely clear. For example, is it the first lab, is it the lab in the ER versus the lab when you are admitted? Is it a lab that's taken at the bedside and read, as opposed to the first lab that's in the laboratory that is electronic? The Committee felt that with a complete definition a comprehensive feasibility and cost study could be conducted. When it was clarified that OSHPD would be specifying those definitions under the direction of the Commission, the Committee was more comfortable with approving the second motion to the Commission which echoed the Technical Advisory Committee motion to move forward with the first priority list with the addition of glucose.

Chairperson Genna asked Committee member Ellis if it would be possible to have a presentation made to the HDPIC or Commission on the feasibility and cost analysis from the California Health Information Association (CHIA). Committee member Ellis agreed that once the definitions were clear CHIA could certainly help address cost and feasibility in a presentation.

Dr. Parker stated that OSHPD had held off defining the data elements until staff received the Commission's recommendation on exactly which data elements would be move forward for further study.

Director Carlisle stated that it was his feeling that it would be better to move forward with a number of data elements that would allow for some attrition, since in all likelihood the number would narrow as staff began to assess the ease and cost effectiveness with which the data could be acquired.

Commissioner Brien made a motion that OSHPD study and review the following 18 data elements:

1. Aspartate Transaminase (AST)
2. K (Serum Potassium)
3. NA (Serum Sodium)
4. pH (blood gas)
5. International Normalized Ratio (INR)
6. Albumin
7. Creatinine
8. Blood urea nitrogen
9. Platelets
10. White blood cells
11. Hematocrit/Hemoglobin
14. Pulse/Heart Rate
15. Systolic/Diastolic Blood Pressure
16. Respiration
17. Temperature
18. Oxygen Saturation (by pulse oximetry)
19. Geocoded Address
23. Operating Physician

Commissioner Fine amended that motion to state that in addition there would be quarterly reports made to the Commission of the progress made by staff under this charge.

Commissioner Moseley stated that she would like to see glucose remain on the list because currently obesity is being discussed so widely in the media. Looking at glucose on admission can be a way of assessing whether or not further studies need to be done. In and of itself it may not give you anything, but it is an indication that further study is indicated.

Commissioner Fine stated that she did not feel that glucose is appropriate. She indicated that she understood that this was an emotional discussion, but that it doesn't relate to the facts of the data determination. It has been scientifically proven that it does relate to quality of care.

Commissioner Brien stated that it does not preclude the collection of glucose, in that it is already being drawn as often part of a routine when a patient comes in, and further tests may be indicated, but a single glucose test, on admission in particular, does not determine whether a patient has diabetes or not, whether a patient has obesity or not, because there are so many factors when a patient comes in pertaining to stress that the glucose level changes.

Commissioner Fine stated that Dr. Pine and Bindman stated that it is so much a part of the normal routine of a hospital that it does not affect quality outcomes. It happens automatically, so that it does not become a separate determinant of quality of care.

Chairperson Genna asked for the motion to be read back. Acting Executive Director Maestas read the motion as made by Dr. Brien and amend by Dr. Fine.

Commissioner Sanchez seconded the motion. The motion was carried.

AB 774 Hospital Fair Pricing Policy Status Report: Kenny Kwong, Manager, Accounting and Reporting Section

The regulations package was approved by the Commission at the February meeting. Since that meeting, the online reporting system has been designed and named the System for Fair Price Hospital Reporting (SyFPHR). The logo for SyFPHR is currently under design.

The presentation covered a short review of the reporting requirements by hospitals, the regulations and timelines for implementation. Manager Kwong then presented a conceptual model of what the facilities would be using to submit their policies to OSHPD and how the general public would access and view this information.

SyFPHR is envisioned as a four-step submission system:

1. Enter Logon ID and password
2. Enter data and attach files
3. Review data and filenames, and submit
4. Confirmation of submission

The submission form, as it is designed at this point, is going to capture the name and address of the contact person for individuals attempting to apply for charity care or discount payment. Additionally, the web address of the facility, which will also appear in the dissemination model, will be collected. In the charity care policy, the Federal Poverty Level (FPL) at which the facility provides free charity care will be collected. With regard to the discount payment policy, the OSHPD will try to capture the range at which facilities offer discount payment. Hospitals will be able to indicate in which languages their charity care policies and application forms are available on the submission form.

After the submission form is completed and submitted, OSHPD will generate and e-mail back to the person submitting the information, confirming the submission.

Individuals from the general public will access the information submitted by healthcare facilities through the homepage by conducting a search for the hospital that they are interested in. The search can be conducted in two ways; first by entering the hospital name, part of the hospital name, zip code, county, or area code; second by using Google maps which can be zoomed in on and would be accompanied by a summary of the healthcare facility including address, FPL, the discount payment level, the languages that the policies are available in. Several links will be included to view or download the policies, procedures and application forms.

Next Meeting: The next meeting will be held on August 24 in Northern California.

Adjournment: The meeting adjourned at 12:20 p.m.

Pending Items:

1. Commissioner Fine requested a presentation on who uses OSHPD Data and in what context the data is used.

2. Chairperson Genna requested that CHIA present to the Commission and the Health Data and Public Information Committee their cost and feasibility finding with regard to the collection of data elements recommended for addition to the Patient Discharge data set once definitions have been finalized.

3. The Commission passed a motion which included a request for quarterly reports on the status of the study and review of additional data elements charged by the Commission to OSHPD staff.